

MARICOPA INTEGRATED HEALTH SYSTEM – HEALTH PLANS (MIHS-HP)
MEDICAL DIRECTOR’S OFFICE

PRIOR AUTHORIZATION/NON-FORMULARY PHARMACY REQUEST FORM

DATE: _____

TO: _____

FROM: _____

PHONE & FAX NUMBER FOR FACILITY: _____

MEMBER NAME : _____

AHCCCS ID #: _____

PRIMARY LANGUAGE: _____

DATE OF BIRTH: _____

MEMBER LOCATION: _____

DRUG REQUESTED:
(*INCLUDE DOSE & SCHEDULE*) _____

MEDICAL NECESSITY: _____

List therapy failure on one or more formulary drugs within the same therapeutic class:

**ATTACH MEDICALLY NECESSARY DOCUMENTATION SUPPORTING
REQUEST IN FORM OF PROGRESS NOTES, CONSULTATION OR
LABS.**

- ☐ Diagnosis and date of onset: _____
- ☐ Plan/length of treatment and expected outcome: _____
- ☐ Surgery and date pertaining to request (if transplant): _____
- ☐ Pharmacy, if known (to expedite member receiving medication): _____
(Consider directing patient to clinic pharmacy if cost is over \$100.)

Attending’s Legibly Printed Name

Attending’s Signature

****Form must be signed by an Attending Provider****

In order to process a Request for Medication, the following Request for Information must be faxed to the MIHS Health Plans Medical Director’s Office at (602) 344-8858.

Information must pertain to the request and be legible. This form must be completely filled out with supporting documentation or delay in processing the request will occur.*

***NOTE: MIHS-Health Plans HAS 72 HOURS TO RENDER A DECISION.**